State Missouri

b. Early and Periodic Screening, Diagnosis, and Treatment Services (cont.)

PSYCHOLOGY/COUNSELING PROGRAM:

Medically necessary psychological/counseling services are covered for individuals under the age of 21 years when the need for the services is discovered through an EPSDT screening service and provided by a licensed psychologist, licensed social worker or licensed professional counselor. Some services require prior authorization to determine the medical necessity of the service recommended.

Psychological/counseling services include the following:

- Assessment
- Testing
- Crisis Intervention
- Individual Therapy
- Family Therapy
- Group Therapy

THERAPY PROGRAM (HCY):

Physical Therapy: Physical therapy services are covered as an EPSDT service to the extent they are medically necessary and include evaluation and treatment related to range of motion, muscle strength, functional abilities and the use of adaptive/therapeutic equipment. Activities include but are not limited to rehabilitation through exercise, massage, the use of equipment and therapeutic activities.

Splinting and casting is a covered service when provided by a licensed physical therapist when medically necessary for the treatment of a patient (includes supplies and fabrication time).

Occupational Therapy: Occupational therapy services are covered as an EPSDT service to the extent they are medically necessary and include evaluation and treatment services. Typical activities related to occupational therapy are: perceptual motor activities, exercises to enhance functional performance, kinetic movement activities, guidance in the use of adaptive equipment and other techniques related to improving motor development.

Splinting and casting is a covered service when provided by a licensed occupational therapist when medically necessary for the treatment of a patient (includes supplies and fabrication time).

Speech/Language Therapy:

Speech/language services are a covered service when provided by a licensed speech pathologist or by a Department of Elementary and Secondary Education (DESE) certified speech therapist who is certified to provide speech/language services as a school district employee. Speech/language therapy is the evaluation and provision of treatment of the remediation and development of age appropriate speech, expressive and receptive languages, oral motor and communication skills. Speech treatment includes activities communication skills. Speech/language therapy includes treatment in one or more of the following areas: articulation, language development, oral motor/feeding, auditory rehabilitation, voice disorders and augmentative communication modes.

State Missouri

b. Early and Periodic Screening, Diagnosis, and Treatment Services (cont.)

REHABILITATION CENTER PROVIDERS (HCY):

Physical Therapy: Physical therapy services are covered as an EPSDT service to the extent they are medically necessary and include evaluation and treatment related to range of motion, muscle strength, functional abilities and the use of adaptive/therapeutic equipment. Activities include but are not limited to rehabilitation through exercise, massage, the use of equipment and therapeutic activities.

Splinting and casting is a covered service when provided by a licensed physical therapist when medically necessary for the treatment of a patient (includes supplies and fabrication time).

Occupational Therapy: Occupational therapy services are covered as an EPSDT service to the extent they are medically necessary and include evaluation and treatment services. Typical activities related to occupational therapy are: perceptual motor activities, exercises to enhance functional performance, kinetic movement activities, guidance in the use of adaptive equipment and other techniques related to improving motor development.

Splinting and casting is a covered service when provided by a licensed occupational therapist when medically necessary for the treatment of a patient (includes supplies and fabrication time).

Speech/Language Therapy: Speech/language services are covered through the EPSDT option. Speech/language therapy is the evaluation and provision of treatment for the remediation and development of age appropriate speech, expressive and receptive languages, oral motor and communication skills. Speech treatment includes activities that stimulate and facilitate the use of effective communication skills. Speech/language therapy includes treatment in one or more of the following areas: articulation, language development, oral motor/feeding, auditory rehabilitation, voice disorders and augmentative communication modes.

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4.c. Family Planning Services

Family Planning is defined as any medically approved diagnosis, treatment counseling, drugs, supplies, or devices which are prescribed or furnished by a provider to individuals of child-bearing age for purposes of enabling such individuals to freely determine the number and spacing of their children. The limitations in the Pharmacy, Physician, Inpatient Hospital and Outpatient Hospital Programs also apply to recipients receiving family planning services under any of the respective programs.

Sterilizations

Voluntary sterilizations are covered if the recipient is at least 21 years old at the time consent is obtained, is not a mentally incompetent individual or an institutionalized individual, and has voluntarily given informed consent. All of the federal requirements for informed consent documentation must be satisfied and the consent form must be attached to the claim.

Hysterectomies

Medicaid will not pay for a hysterectomy with the sole or main purpose of rendering an individual permanently incapable of reproducing. Hysterectomies for medically necessary reasons are covered only if the federal requirements for prior certification of the giving and receipt of information are satisfied. Hysterectomies may also be covered if performed as a life preserving necessity and prior acknowledgement was not possible or where the individual was already sterile. These conditions require physician certification of the circumstances.

5.a. Physician's Services

A new patient office visit is limited to one per provider for each recipient. An established patient extended or comprehensive visit is limited to one per provider per year for each recipient.

Coverage of services related to the performance of certain specified elective surgical procedures requires the recipient obtain a documented medical second opinion. Coverage is provided for a documented third opinion, at the recipient's choice, when the second opinion fails to confirm the surgery recommendation of the first opinion.

Other physician services limitations apply in the areas of physical medicine, hospital visits, house calls, nursing homes, surgery, anesthesia, laboratory, radiology, injections, psychiatry, and maternity care. The specific limitations may be found in the ~~Physician Pro~~vider Manual.

Bone marrow, heart, kidney, liver, lung and certain restricted multiple organ transplants and related transplantation services are covered when prior authorized. Corneal transplants are covered without a requirement of prior authorization.

5.b. Medical and surgical services furnished by a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the state in which he performs such function, and who is acting within the scope of his license when he performs such functions, to the extent such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine are covered. The specific limitations may be found in the Dental Provider Manual.

6.a. Podiatrist Services

Podiatrist services are limited to medical, surgical, and mechanical services for the foot or any area not above the ankle joint.

A new patient office visit is limited to one per provider for each recipient. An established patient extended or comprehensive visit is limited to one per provider per year for each recipient.

Other service limitations apply in the areas of physicial medicine, hospital visits, house calls, nursing homes, surgery, anesthesia, laboratory, radiology, and injections. The specific limitations may be found in the Podiatry Provider Manual.

State Missouri

6.b. Optometrists' Services

Eye Examinations

Either one limited or one comprehensive eye examination is allowed per recipient per calendar year. If additional examinations are required during the year for cataract examinations or for prescription changes of 0.50 diopters or greater, a Medical Necessity Form must be completed and attached to the claim for payment.

Eyeglasses

A maximum of one pair of eyeglasses every two (2) years (within a 24-month
period of time) is allowed for all Medicaid recipients, regardless of age. Eyeglasses are covered only when the prescription is at least 0.75 diopters for one or both eyes (0.75 diopters for each eye).

Supportive documentation of medical necessity is required for the repair of frames or replacement of parts of frames. Replacement of lenses covered within 24-months of Medicaid eyeglasses only when supported by Medical Necessity and prescription for change of 0.50 diopters for at least one eye.

Prior Authorization is required for any optometric service for recipients residing in nursing homes when provided in the nursing home.

Therapeutic certified optometrists who have enrolled as such in the Medicaid program may be reimbursed for office visits, hospital visits, and nursing home visits.

6.d. Nurse Practioner/Clinical Nurse Specialist Services

Advance Practice Nurse services are limited to those services provided by properly licensed and certified nurse practitioners and clinical nurse specialists practicing within the scope of state law.

A certified nurse practioner must be a registered nurse and hold current certification in the area of nursing speciality practice by the national certifying body of -

- The Organization for Obstetric, Gynecologic and Neonatal Nurse (NAACOG) Certification Corporation as an obstetrician/gynecologist (OB/GYLN) nurse practitioner or neonatal nurse practitioner;
- The American Nurses Association as a family nurse practitioner, or adult nurse practioner, or gerontological nurse practitioner, or
- The National Certification Board of Pediatric Nurse Practioners and Nurses as a pediatric nurse practitioner.

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6.d . Nurse Practitioner/Clinical Nurse Specialist Services (cont'd)

A clinical nurse specialist - must be a registered nurse and have a master's degree in the area of clinical nursing speciality practice or be currently certified by the American Nurses Association as a clinical nurse specialist in the area of specialty practice.

A new patient office visit is limited to one per provider for each recipient. An established patient extended or comprehensive visit is limited to one per provider per year for each recipient.

Other service limitations apply in the areas of physical medicine, hospital visits, nursing home, surgery, laboratory, injections, and maternity care. The specific limitations may be found in the Physician/Nurse Practioner Provider Manual.

Reference Nurse Practioner Services 3.1-A #23 page 18d.

Certified Diabetes Educator, Registered Dietician, Registered Pharmacist Diabetic Education Services

Medically appropriate diabetes self-management education services used in the management and treatment of type 1, type 2 and gestational diabetes are covered when prescribed by a physician or a health care professional with prescribing authority and may be provided by a Certified Diabetes Education (CDE), Registered Dietician (RD), or Registered Pharmacist (RPH).

- Certified Diabetes Educator (CDE): Must hold a permanent Missouri license as a registered nurse or physician. Must also hold current certification from the National Certification Board for Diabetes Educators (NCBDE) through the American Association of Diabetes Educators (AADE). The CDEs practice under The Scope of Practice for Diabetes Educators developed by the American Association of Diabetes Educators.

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- Registered Dietician (RD): May hold a permanent Missouri license as a registered nurse, physician, social worker, pharmacist, registered dietician or other health care professional. Must also hold current certification from the Commission on Dietetic Registration through the American Dietetic Association (ADA). The RDs practice under American Dietetic Association Standards of Professional Practice by the ADA. Effective July 1, 1999, a permanent Missouri license as a licensed registered dietician will also be required.

- Registered Pharmacist (RPh): Must hold a permanent Missouri license as a licensed pharmacist and must have completed the National Community Pharmacists Association (NCPA) "Diabetes Care Certification Program" or completed the American Pharmaceutical Association (APhA)/American Association of Diabetes Educators (AADE) certification program "Pharmaceutical Care for Patients with Diabetes".

An initial assessment will be reimbursed once per lifetime. An initial assessment must be performed by either a physician or a CDE. If the initial assessment is performed by a CDE the assessment must be prescribed by a physician or health care provider with prescribing authority. The initial assessment should include but not be limited to information from the patient on the following: health and medical history; use of medications; diet history; current mental health status; use of health care delivery systems; life-style practices; physical and psychological factors; barriers to learning; family and social supports; and previous diabetes education, actual knowledge, and skills.

Two subsequent visits will be reimbursed each 12 months when prescribed by a physician or a health care professional with prescribing authority. Documentation of medically appropriate diabetes self-management education services will include:

- Any significant change in the patient's symptoms, condition or treatment; or
- Need for re-education or refresher training.

The RD will provide medical nutrition therapy and diet education.

The RPH will provide comprehensive instruction in the pathophysiology of diabetes and the acute and long-term complications of diabetes. The RPH will also teach current approaches to the medical management of diabetes with special emphasis on nutritional interventions and pharmacologic therapies.

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7. Home Health Services

The Medicaid Program will pay for home health care when the attending physician has developed a written Plan of Care certifying the need for home health services. The Plan of Care must be reviewed by the physician at least every 60 days, or at such time as the Plan of Care is interrupted by a period of hospitalization. The certification period can be up to, but never exceed, two calendar months and mathematically never exceed 62 days.

State Missouri

Home health services are only covered for a Medicaid recipient if provided in the recipient's home. Home health visits will be limited to the number of visits on a Plan of Care. The number of home health visits (skilled nurse and aide) during one year may not exceed 100, except skilled nurse visits as approved by the Division of Medical Services or their designee. These services are restricted to performance by a registered or licensed practical nurse, home health aide, physical therapist, occupational therapist, or speech therapist, in the employ of or under contract to a home health agency licensed by the State of Missouri. To be eligible for home health services, a recipient must require the services of a skilled nurse or therapist, as defined in paragraphs 7.a and d below, and be confined to his home. The services which are required must be reasonable and necessary for the treatment of an illness or injury and must require performance by the appropriate licensed or qualified professional to achieve the medically desired result.

7.a. Intermittent or part-time nursing service

Intermittent skilled nursing care by a registered or licensed practical nurse which is reasonable and necessary for the treatment of an injury or illness is covered when delivered in accordance with the plan of treatment. Purely preventive care is not covered.

7.b. Home-health aide services

Home health aide services must be specified on the plan of care and needed concurrently with covered skilled nursing or physical, occupational, or speech therapy services. The services of the aide must be reasonable and necessary to maintain the recipient at home and there must be no other person who could and would perform the service.

7.c. Medical supplies, equipment, and appliances

Medically necessary supplies which are not routinely furnished in conjunction with patient care visits and which are direct, identifiable services to an individual patient are reimbursable to the agency. Examples include: Ostomy sets and supplies, irrigation sets and supplies, tapes, catheters and supplies.

Needed items of medical equipment prescribed by a physician are available to all recipients including recipients of home health, through the Durable Medical Equipment program.

Substitute per letter dated 02/04/94

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7.d. Physical therapy, occupational therapy, and speech therapy: Skilled therapy services as defined under 42 CFR 440.70(b)(4) will be considered reasonable and necessary for treatment under the home health program if the following conditions are met.

(A) The Services:

1. Must be consistent with the nature and severity of the illness, and the recipient's particular medical needs, and;

2. Must be considered, under accepted standards of medical practice, to be specific and effective treatment for the patient's condition, and;

3. Must be provided with the expectation, based on the assessment by the attending physician of the recipient's rehabilitation potential, that the recipient's condition will improve materially in a reasonable and generally predictable period of time, and;

4. Are necessary for the establishment of a safe and effective maintenance program, or for teaching and training a caregiver.

(B) Therapy services may be delivered for one certification period (up to 62 days), if services are initiated within 60 days of onset of the condition or within 60 days from date of discharge from the hospital, if the recipient was hospitalized for the condition. Prior authorization to continue therapy services beyond the initial certification period may be requested by the home health provider. Prior authorization requests will be reviewed by Division of Medical Services, and approval or denial of the continuation of services will be based on the services continued adherence the criteria used in the original determination as specified above and the recipient's continuation as medically homebound as required for home health services.

9. Clinic services

Clinic services are payable to a clinic only if

(1) The clinic has signed a participation agreement and has been set up as a participating provider under one of the following provider types: Independent Clinic, Public Health Department Clinic, Planned Parenthood Clinic, Professional Clinic Optometry, Community Mental Health Center, Adult Day Health Care Center.